Licensed Mental Health Counselor Application Packet

Contents:

Important Social Security Number Information:

You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, contact the Customer Service Center at 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Mail your application with initial documentation and your check or money order payable to:

Department of Health
PO Box 1099
Olympia, WA 98507-1099

Send other documents not sent with initial application to:

Mental Health Counselor Credentialing
PO Box 47877
Olympia, WA 98504-7877

Contact us:

360.236.4700

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Application Instructions Checklist

Important background check Information: Washington State law authorizes the Department of Health to obtain fingerprint-based background checks for licensing purposes. This check may be through the Washington State Patrol and the Federal Bureau of Investigation (FBI). This may be required if you have lived in another state or if you have a criminal record in Washington State. This would be at your own expense.

All information should be typed or printed clearly in blue or black ink. It is your responsibility to submit the correct forms required.

☐ **Do you hold a credential in Washington State?** Check yes or no. If you do hold a credential in Washington State, please provide your license number.

☐ **Application Fee.** This fee is non-refundable. You can check the online **fee page** for current fees.

☐ **1. Demographic Information:**
Social Security Number: You must list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.

Legal Name: List your full name: first, middle, and last.

Definition of legal name: "Legal name" is the name appearing on your official certificate of birth or, if your name has changed since birth, on an official marriage certificate or an order by a court. The court must have the legal authority to change your name. We may ask you to prove your legal name. If you use any name other than your legal name on this form, your application may be denied.

Birth date: Provide the month, day, and year of your birth.

Birth place: Provide the city, state, and country you were born in.

Address: List the address we should use to deliver any information about your credential. Be sure to include the city, state, zip code, and country. This will be your permanent record with Department of Health until we have been notified of a change.

Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers.

Email: Enter your email address, if you have one.

Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See **WAC 246-12-300**.

☐ **2. Personal Data Questions:**

All applicants must answer the same personal data questions. They are focused on your fitness to practice the essential skills of this profession.

If you answer “yes” to any questions in this section, you must provide an appropriate explanation. You must also provide the documentation listed in the note after the question. If you do not provide this, your application is incomplete and will not be considered.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can get copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- Another jurisdiction means any other country, state, federal territory, or military authority.

☐ **3. Other License, Certification, or Registration:**
List **all** states (including Washington State) where credentials are or were held. Specifically list credentials granted by examination, endorsement, or grandparenting.

An Out-of-State credential verification form is enclosed and must be sent to each state listed on your application. Enter your full name and birth date at the top of the form so the state may identify you. Also contact each state board listed for any fees they might charge you for processing the verification form.

☐ **4. Examination Data**
If you have taken the **NCE** or **NCMHCE** examinations, you are considered to have met the examination requirement. You must get written verification from **NBCC**, sent **directly** to the department.

☐ **5. Education:**
Graduation from a master’s or doctoral level educational program in mental health counseling or a related field, from an approved college or university. Please request official transcripts to be sent directly from your college or university to us.

If you have a mental health counselor associate credential, you do not need to resubmit your transcripts.

☐ **6. Experience:**
Beginning with current employment, list all activities and account for all periods of time from graduation to the present. A resume will **not** substitute for completion of the application. Please use the initials **N/A** (not applicable) if you have not had professional training and experience.

☐ **7. Course Content Identification for Licensed Mental Health Counselor:**
Behavioral science in a field relating to mental health counseling includes a core of study relating to counseling theory and counseling philosophy. Either a counseling practicum, or a counseling internship, or both, must be included in the core of study. Exclusive use of an internship or practicum used for qualification must have incorporated supervised direct client contact. This core of study must include seven content areas from the entire list in subsections (1) through (17) of **WAC 246-809-221**, five of which must be from content areas in subsections (1) through (8) of this subsection.

☐ **8. Aids Education and Training Attestation**
Read the AIDS education and training attestation. AIDS training may include self study, direct patient care, courses, or formal training. A minimum of four hours is required. Course content can be found in **WAC 246-12-270**.

☐ **9. Continuing Education Attestation**
Complete 36 hours of continuing education, with six hours in professional ethics. See **RCW 18.225.090**.

☐ **10. Applicant's Attestation and Signature**
You must sign and date this for us to process the application.

We appreciate your interest in obtaining a credential. You will be notified in writing if further documentation is required. If your application is incomplete, you will be mailed or emailed a letter regarding the deficiencies.

- The application is considered incomplete if requested information is left blank. Put N/A or place a line through a section instead of leaving it blank.
- You must keep your address up to date in order to receive a courtesy renewal notice. Any renewal postmarked or presented to the department after midnight on the expiration date is late.

To receive notifications regarding the profession, please join our List-Serv at: **List-Serv**.

Notice to Spouses and Registered Domestic Partners of Military Personnel Transferring to Washington

Under a new state law, a spouse or registered domestic partner of military personnel transferring to Washington may receive his or her health professional license more quickly. In order for us to do this, please complete the additional form found at **the military resources page** and include supporting documentation with your application.

Experience Requirement

A minimum of thirty-six months of full-time counseling or three thousand hours of postgraduate mental health counseling under the supervision of a qualified licensed mental health counselor or equally qualified licensed mental health practitioner who meets the qualifications of an approved supervisor. See **WAC 246-809-234**.

The Verification of Mental Health Supervised Postgraduate Experience Forms must be sent to approved supervisors that can verify a minimum of 36 months of full-time counseling or 3000 hours of postgraduate supervised work experience:

- 1200 of the 3000 hours must be direct counseling with individuals, couples, families, or groups and
- 100 hours must be spent in immediate supervision with a qualified licensed mental health counselor.
- If you had more than one supervisor, a separate form must be used for each supervisor.

Council for Accreditation of Counseling and Related Educational Programs (CACREP) Policy

Practitioners who have graduated from a CACREP accredited program at a master's or doctoral level will be granted credit for 50 hours of postgraduate supervision and 500 hours towards postgraduate experience.

Examination Information

- It is the applicant's responsibility to contact the National Board of Certified Counselors (NBCC) at www.nbcc.org to register to take the examination.
- The department accepts the National Counselor Examination for Certification and Licensure (NCE) or the National Clinical Mental Health Counselor Examination (NCMHCE) to meet the licensure requirements.
- It is the applicant's responsibility to ensure that NBCC sends official verification of the applicant's successful completion of the examination.

Washington State Department of Health

Background Check Stamp Here

Date Stamp Here

Revenue: 0207030000

Mental Health Counselor License Application

Do you hold a credential in Washington State? ☐ No ☐ Yes

If yes, license # _____

1. Demographic Information

Social Security Number (If you do not have a social security number, see instructions)

☐ Male
☐ Female

Name First Middle Last

Birth date (mm/dd/yyyy)

Place of birth

City | State | Country

Address

City | State | Zip | County

Country

Phone (enter 10 digit #) | Fax (enter 10 digit #) | Cell (enter 10 digit #)

Email address:

Mailing address if different from above address of record

City | State | Zip | County

Country

Note: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the department.

Have you ever been known under any other name(s)? ☐ Yes ☐ No
If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No
If yes, list name(s):

For Office Use Only

License # _____ Issue Date_____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, intellectual disabilities, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

   If you answered yes to question 1, explain:

   1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

   1b. How your field of practice, the setting or manner of practice has reduced or eliminated the limitations caused by your medical condition.

   Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

   The licensing authority may require you to undergo one or more mental, physical or psychological examination(s). This would be at your own expense. By submitting this application, you give consent to such an examination(s). You also agree the examination report(s) may be provided to the licensing authority. You waive all claims based on confidentiality or privileged communication. If you do not submit to a required examination(s) or provide the report(s) to the licensing authority, your application may be denied.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means within the past two years.

   "Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means within the past two years.

   Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

   Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile in any state or jurisdiction? ☐ ☐

   Note: If you answered "yes" to question 5, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and will not be considered.

   To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

2. Personal Data Questions (Cont.)

	Yes	No
a. Are you now subject to criminal prosecution or pending charges of a crime in any state or jurisdiction	☐	☐

Note: If you answered "yes" to question 5a, you must explain the nature of the prosecution and/or charge(s). You must include the jurisdiction that is investigating and/or prosecuting the charges. This includes any city, county, state, federal or tribal jurisdiction. If charging documents have been filed with a court, you must provide certified copies of those documents. If you do not provide the documents, your application is incomplete and will not be considered.

b. If you answered "yes" to question 5a, do you wish to have decision on your application delayed until the prosecution and any appeals are complete?	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceeding to have:		
a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes?	☐	☐
b. Diverted controlled substances or legend drugs?	☐	☐
c. Violated any drug law?	☐	☐
d. Prescribed controlled substances for yourself?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach an explanation and provide copies of all judgments, decisions, and agreements?	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority?	☐	☐
9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority?	☐	☐
10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession?	☐	☐

3. Other License, Certification, or Registration

List all states (including Washington State) where licenses, certifications and registrations are or were held.

State/ Jurisdiction	Credential Type	Method Licensed			Credential	
		Exam	Endorsement	Grandfathered	Year Issued	Number

An Out-of-State Credential Verification form is enclosed and must be sent to each state listed above. Enter your full name and birth date at the top of the form so the state may identify you. Also contact each state board listed for any fees they might charge you for processing the verification form.

4. Examination Data

Have you taken and passed the National Board of Certified Counselors?
NCE ☐ Yes ☐ No Year? _____ NCMHCE ☐ Yes ☐ No Year? _____

Are you currently nationally certified through the NBCC? ☐ Yes ☐ No Year? _____

Official verification in the form of scores or certificate must be sent directly from NBCC to the Department of Health.

5. Education

List in date order, most recent to later, your graduate school(s) attended, major, and month and year the degree was granted. A transcript is to be requested from the graduate school(s) and sent **directly** from the graduate school to the Department of Health, Mental Health Counselor Program.

Graduate School	Degree and Major	Degree Granted	
		Month	Year

6. Experience

List in date order, most recent to later, all your experience.

Indicate Type of Experience or Practice and Location	Inclusive Dates of Experience	
	Entrance Date (mm/yyyy)	Leaving Date (mm/yyyy)

7. Course Content Identification for Licensed Mental Health Counselors

Requirement: A masters or doctoral degree in mental health counseling or a related field with the substantial equivalent in subject area. See WAC 246-809-221.

Subject content includes a core of study relating to counseling theories, counseling philosophy, counseling practicum, counseling internship, and should incorporate content in professional ethics and law and shall include at least five content areas (1) through (17) of this subsection and at least two additional content areas from the entire list. If you have a mental health counselor associate credential you do not need to complete this section.

Content Area	Course #	Course Title
1) Assessment / diagnosis		
2) Ethics / Law		
3) Counseling individuals		
4) Counseling groups		

7. Course Content Identification (Cont.)

Content Area	Course #	Course Title
5) Counseling couples and families		
6) Developmental psychology (may be child, adolescent, adult or life span)		
7) Abnormal psychology/psychopathology		
8) Research and evaluation		
9) Career development counseling		
10) Multicultural concerns		
11) Substance / chemical abuse		
12) Physiological psychology		
13) Organizational psychology		
14) Mental health consultation		
15) Developmentally disabled persons		
16) Abusive relationships		
17) Chronically mentally ill		

8. Aids Education and Training Attestation

I certify I have completed the minimum of four hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two years and be prepared to submit those records to the department if requested.

I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

☐ School curriculum
☐ Employer/Other

Applicants Initials	Date

9. Continuing Education Attestation

I, _____, declare I completed 36 hours of continuing education, with six hours in professional ethics.

Applicants Initials	Date

10. Applicant's Attestation

I,_____, declare under penalty of perjury under the
(Name of Applicant)
laws of the state of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____ at _____
(mm/dd/yyyy) (City, state)

by: _____
(Original Signature of Applicant)

Washington State Department of Health
Mental Health Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Verification of Mental Health Counselor Supervised Postgraduate Experience

Applicant:

Use a separate form for each supervisor verifying your postgraduate supervision and professional experience for each practice setting. This form may be duplicated. Fill out Section 1 and forward to the supervisor for completion.

1. Print or Type Clearly:

Name Last	First	Middle	Birth Date (mm/dd/yyyy)
Address			
City	State		Zip Code

2. Approved Supervisor: (An approved licensed mental health counselor or equally qualified licensed mental health practitioner)

The above individual seeks verification of supervised mental health counselor postgraduate experience for licensure as a mental health counselor. Please complete the following:

Supervisor Name		Current Phone
Credential State		First Issuance Date
Current Street Address		
City	State	Zip Code

3. Supervised Postgraduate Experience:

Applicants must have a minimum of **thirty-six months** of full time counseling **or 3,000 hours** of supervised postgraduate experience under the supervision of an approved licensed mental health counselor or equally qualified licensed mental health practitioner. Please complete the actual months in the space provided below.

Months of Supervision	From mm	dd	yyyy	To mm	dd	yyyy

	Hours Required	**Total Hours Verified**
A. **Immediate Supervision,** means a meeting with an approved supervisor, involving one supervisor and no more than two licensing consultants.	At least 100	
B. **Direct Counseling,** with individual couples, families, or groups.	At least 1,200	
C. **All other hours,** hours not listed in section A or B may be listed here	Unlimited	
D. **Total Hours required**	**A+B+C = D Total of 3,000**	

Supervisor

I certify that the above information is, to the best of my knowledge, accurate and complete. I understand that the Department may request additional information, if it is needed, to evaluate the application of the individual named on this document. I also attest I meet or exceed the educational and supervision requirements to be an approved supervisor.

Signature: _____ Date:_____

Return this form to the address above.

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Washington State Department of Health
Mental Health Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Out-of-State Credential Verification

Applicant Name: _____ Birth date: _____
mm/dd/yyyy

I, _____, Secretary of _____,

hereby certify that _____
Official Name of Board

was granted state ☐ Registration ☐ Certificate ☐ License

Number: _____ to practice _____

in the State of _____ on the _____ day of _____, 20_____.

Legal/Disciplinary Action: ☐ Yes ☐ No

If Yes, explain: _____

_____

_____

On the basis of: _____

_____

Did applicant take and pass the NBCC Exam?

☐ Yes ☐ No Passing Score:

☐ Yes ☐ No 100 hours immediate postgraduate supervision with an approved licensed mental health practitioner or equally qualified licensed mental health practitioner.

☐ Yes ☐ No 3000 hours supervised postgraduate experience with approved licensed mental health practitioner or equally qualified licensed mental health practitioner 1200 hours must be direct counseling with individuals, couples, families or groups.

☐ Yes ☐ No 36 months full time counseling with a qualified licensed mental health counselor.

Status of License: ☐ Current Expiration Date: _____

☐ Expired Date: _____

S E A L

_____
Official Name of Board Phone (enter 10 digit #)

_____
Secretary

_____
Date Certification Prepared

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Washington State Department of Health
Mental Health Credentialing
PO Box 47877
Olympia, WA 98504-7877
360.236.4700

Accommodation Request

If you have a disability and require accommodation in taking the examination, please complete and submit this form. The information requested below and any documentation regarding your disability and your need for accommodation in testing will be considered strictly confidential and will not be shared with any outside source without your express written permission. [Section 504 of the Rehabilitation Act (29 USC 12101)].

Name: _____

Address: _____

Phone (enter 10 digit #): _____Social Security Number: _____

Accommodations requested for the: _____License Examination
Date

Type of Disability: _____

Requesting the following accommodation(s) at the testing site: _____

_____

Signed: _____Date:_____

Documentation of Disability Related Needs

If you have a learning disability, a psychological disability, or other hidden disability that requires an accommodation in testing, please have this section completed by an appropriate professional (learning specialist, doctor, psychologist, psychiatrist) to certify that your disabling condition requires the requested test accommodation.

If you have existing documentation of having the same or similar accommodation provided to you in another test situation, you may submit such documentation instead of having this portion of the form completed.

I have known _____ since_____
Test Applicant Date

The applicant has the disability:_____

Diagnosed by the following tests or studies:_____

I recommend the following accommodation(s) be provided for this individual: _____

_____

_____

Name: _____

Address: _____

Title: _____ Phone: _____

Date: _____ License Number: _____

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Washington State Department of Health
Mental Health Credentialing
P.O. Box 47877
Olympia, WA 98504-7877
360.236.4700

Approved Supervisor
Licensed Mental Health Counselor

To the Supervisor:

Please review **WAC 246-809-234**. To supervise a license candidate, you shall hold a license without restrictions that has been in good standing for at least two years.

You shall not be a blood or legal relative or cohabitant of the license candidate, license candidate's peer, or someone who has acted as the license candidate's therapist within the last two years.

Prior to the commencement of any supervision you shall provide the license candidate this declaration, stating that you have met the requirements of **WAC 246-809-234** and that you qualify as an approved supervisor.

As an approved supervisor, I attest that I have completed the following:

A minimum of fifteen clock hours of training in clinical supervision obtained through:

- A supervision course
- Continuing education credits on supervision
- Supervision of supervision
- Or any combination of these

And twenty-five hours of experience in supervision of clinical practice

I attest that I will gain full knowledge of the supervisee's practice activities including:

- Practice setting
- Recordkeeping
- Financial management
- Ethics of clinical practice
- A backup plan for coverage

Declaration of Supervision—must be completed by Supervisor and provided to license candidate prior to the commencement of supervision in accordance with WAC 246-809-234.

I, _____ a licensed _____ in the
Name of Supervisor

State of _____ with license number _____ attests to _____
Name of License Candidate

that I have read and met all the requirements in connection with **WAC 246-809-234**.

_____
Signature of Supervisor

_____
Date

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RCW/WAC and Online Web Site Links

RCW and WAC Links

Uniform Disciplinary Act..... RCW 18.130

Administrative Procedure Act ..... RCW 34.05

Administrative procedures and requirements ..... WAC 246-12

Standards of professional conduct ..... WAC 246-16

Licensed Mental Health Counselor Laws ..... RCW 18.225

Licensed Mental Health Counselor Rules ..... WAC 246-809

On-Line

AIDS Training Resources ..... Reference Page

Licensed Mental Health Counselor..... Web Page